MDS 3.0 Training
Payment Items and Documentation Requirements

Case Mix Team
February 2021
Mini-Series #3

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MDS 3.0 Training
Payment Items and Documentation

Session #3 Agenda: Payment Items and Documentation

- Welcome and overview
- Questions from Session #2
- Section G
- Section K
- Section N
- Section Z
- Section X – corrections
- Questions

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Section G - Functional Status

Intent: Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.

Section G will continue to be completed and used as the primary source to determine payment for long term care residents in Maine. The new item set will be implemented by CMS on 10/1/2023, at the earliest. This tentative date represents two full fiscal years after the Public Health Emergency ends.

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Section G -
Payment Items

G0110A1, 2 Bed mobility: Self-performance & Support
G0110B1, 2 Transfer: Self-performance & Support
G0110I 1, 2 Toileting: Self-performance & Support
G0110H1 Eating: Self-performance Only

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Section G - G0110

1. ADL Self-Performance

Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. ADL Support Provided

Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

1. Self-Performance	2. Support

↓ Enter Codes in Boxes ↓

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ADL Documentation handout for CNAs

Self performance Codes

0= **Independent: NO TALK, NO TOUCH**
Staff does no assist, instruct, nor cue: resident does All activity ALONE no monitoring, no hands on assistance. (with your eyes, you watched the resident thru the door)

1=**Supervised: TALK, NO TOUCH**
Staff provides instructions or cueing (verbal), but does not provide physical (hands on) assistance. Oversight and cueing staff uses mouth/voice only. NO HANDS

2= **Limited assistance: TALK and TOUCH**
Staff talks to give instructions or cues and touches resident to assist: can be as simple as putting hands on resident's back or holding his/her elbow while walking. Hands used for more than set up, but does not lift any part of the resident. The resident is highly involved, you did some hands on assist but it was NON-WEIGHT BEARING

3 = **Extensive assistance: TALK, TOUCH, and LIFT**
Staff uses muscle power to lift, move, or "shift" resident. This includes lifting legs into bed, "scooting" buttocks into positioning in bed, lifting arm to assist in self feeding. The resident performed part of the activity, but WEIGHTBEARING ASSIST (someone lifted a part of the body) was required.

4 = **Total Dependence: ALL ACTION BY STAFF**
Resident dose not participate at all in any part of the activity being done for him/her. The resident didn't lift a finger to help

8 = **the activity didn't occur during the entire shift.**

IF THE STAFF MEMBER HAS TOUCHED THE RESIDENT AT ALL, CODE IS AT LEAST LIMITED ASSIST.

STAFF PERFORMANCE

0 = No staff performance required, zip, zero, nada.

1= set up help only, maybe you undid a cover, set the wheelchair at bedside or set out grooming items

2= ONE person. Physically assisted by one person

3 = 2 or more physically assisted.

8= Activity didn't occur during the whole shift.

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Section G Self Performance

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all.
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

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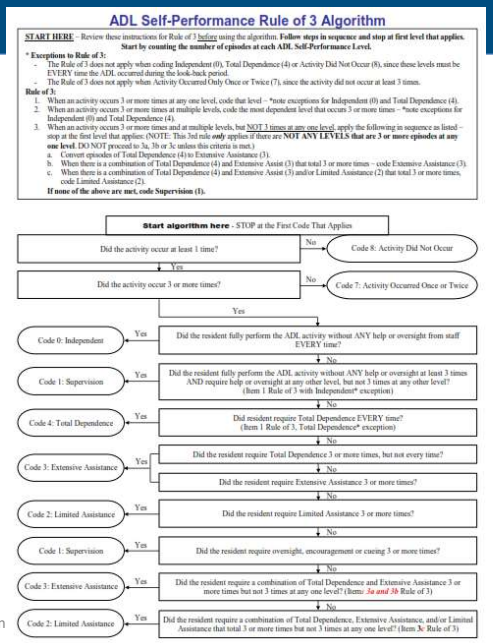

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Coding Tips

- Do **NOT** include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0110 I.
- **Differentiating between guided maneuvering and weight-bearing assistance:** determine **who** is supporting the weight of the resident's extremity or body. For example, if the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is "weight-bearing" assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his or her mouth, this is guided maneuvering.

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- **Code Supervision** for residents seated together or in close proximity of one another during a meal who receive individual supervision with eating.
- General supervision of a dining room is not the same as individual supervision of a resident and **is not** captured in the coding for Eating.
- **Code extensive assistance (1 or 2 persons):** if the resident with tube feeding, TPN, or IV fluids did not participate in management of this nutrition but did participate in receiving oral nutrition. This is the correct code because the staff completed a portion of the ADL activity for the resident (managing the tube feeding, TPN, or IV fluids).
- **Code totally dependent in eating:** only if resident was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by staff) and did not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedure).

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Coding activity did not occur, 8:

- **Toileting** would be **coded 8, activity did not occur**: only if elimination did not occur during the entire look-back period, or if family and/or non-facility staff toileted the resident 100% of the time over the entire 7-day look-back period.
- **Locomotion** would be **coded 8, activity did not occur**: if the resident was on bed rest and did not get out of bed, and there was no locomotion via bed, wheelchair, or other means during the look-back period or if locomotion assistance was provided by family and/or non-facility staff 100 % of the time over the entire 7-day look-back period.
- **Eating** would be **coded 8, activity did not occur**: if the resident received no nourishment by any route (oral, IV, TPN, enteral) during the 7-day look-back period, if the resident was not fed by facility staff during the 7-day look-back period, or if family and/or non-facility staff fed the resident 100% of the time over the entire 7-day look-back period.

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Coding Scenario

During the look-back period, Mr. S was able to toilet independently without assistance **18** times. The other two times toileting occurred during the 7-day look-back period, he required the assistance of staff to pull the zipper up on his pants. This assistance is classified as non-weight-bearing assistance. The assessor determined that the appropriate code for G0100I, Toilet use was Code 1, Supervision. (RAI Manual, page G-23)

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Rationale: Toilet use occurred 20 times during the look-back period. Non-weight bearing assistance was provided two times and 18 times the resident used the toilet independently.

Independent (i.e., Code 0) cannot be the code entered on the MDS for this ADL activity because in order to be coded as Independent (0), the resident must complete the ADL without any help or oversight from staff every time. Mr. S did require assistance to complete the ADL two times; therefore, the Code 0 does not apply.

Code 7, Activity occurred only once or twice, did not apply because even though assistance was provided twice during the look-back period, the activity itself actually occurred 20 times.

The assistance provided to the resident did not meet the definition for Limited Assistance (2) because even though the assistance was non-weight-bearing, it was only provided twice in the look-back period.

The ADL Self-Performance coding level definitions for Codes 1, 3 and 4 did not apply directly to this scenario either.

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The first Rule of 3 does not apply because even though the ADL activity occurred three or more times, the non-weight-bearing assistance occurred only twice.

The second Rule of 3 does not apply because even though the ADL occurred three or more times, it did not occur three times at multiple levels.

The third Rule of 3 does not apply because the ADL occurred three or more times, at the independent level. Since the third Rule of 3 did not apply, the assessor knew not to apply any of the sub-items.

However, the final instruction to the provider is that when neither the Rule of 3 nor the ADL Self-Performance coding Level definitions apply, the appropriate code to enter in Column 1, ADL Self-Performance, is Supervision (1); therefore, in G0110I, Toilet use, the code Supervision (1) was entered.

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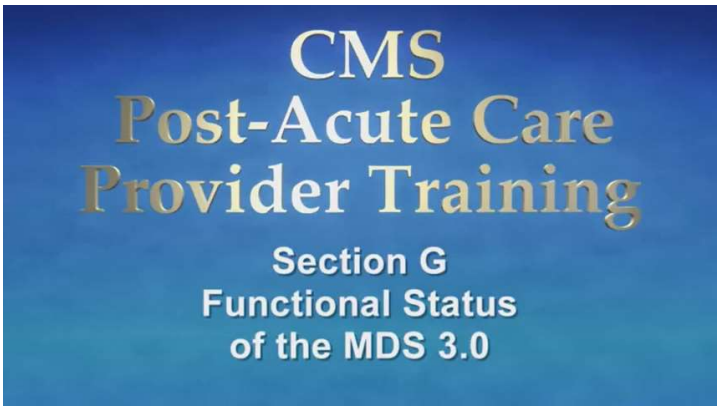

https://youtu.be/t-6e5NV4j6k

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Section K
Swallowing/Nutritional Status

Intent: The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

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Section K: Weight Loss/Gain

K0100A, B, C, and D are all payment items for PDPM

K0100. Swallowing Disorder Signs and symptoms of possible swallowing disorder ↓ Check all that apply	
☐	A. Loss of liquids/solids from mouth when eating or drinking
☐	B. Holding food in mouth/cheeks or residual food in mouth after meals
☐	C. Coughing or choking during meals or when swallowing medications
☐	D. Complaints of difficulty or pain with swallowing
☐	Z. None of the above

K0300: Weight Loss

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Section K - Nutritional Approaches

K0510: Approaches

A. Parenteral / IV Feeding

B. Feeding Tube

C. Mechanically Altered Diet

D. Therapeutic Diet

Z. None of the above

K0510. Nutritional Approaches Check all of the following nutritional approaches that were performed during the last **7 days** 1. **While NOT a Resident** Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank 2. **While a Resident** Performed ***while a resident*** of this facility and within the ***last 7 days***	1. While NOT a Resident ↓ Check all that apply	2. While a Resident
A. **Parenteral/IV feeding**	CATs RUG III PDPM	CATs RUG III PDPM
B. **Feeding tube** - nasogastric or abdominal (PEG)	CATs RUG III PDPM	CATs RUG III PDPM
C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)		CATs PDPM
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)		CATs
Z. **None of the above**	☐	☐

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K0510 Assessment Guidelines

The following items are **NOT** coded in K0510A:

- ✓ IV medications
- ✓ IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
- ✓ IV fluids administered solely as flushes
- ✓ Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis

RAI Manual pages K-11 through K-13

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K0710 Percent Intake by Artificial Route

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B		
2. While a Resident Performed ***while a resident*** of this facility and within the ***last 7 days*** **3. During Entire 7 Days** Performed during the entire ***last 7 days***	**2. While a Resident**	**3. During Entire 7 Days**
	Enter Codes	
A. Proportion of total calories the resident received through parenteral or tube feeding 1. 25% or less 2. 26-50% 3. 51% or more	PDPM	RUG III PDPM
B. Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more	PDPM	RUG III PDPM

If the resident took no food or fluids by mouth (NPO) or took just sips of fluid, stop here and code 3, 51% or more.

If the resident had more substantial oral intake than this, *consult with the dietician*.

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K0710B Average Fluid Intake per Day by IV or Tube Feeding

Code for the average number of cc per day of fluid the resident received via *IV or tube feeding*. Record what was actually received by the resident, not what was ordered.

- Code 1: 500 cc/day or less
- Code 2: 501 cc/day or more

K0710A and B (column 3) are payment items for residents receiving nutrition via IV or Tube Feeding

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Section N: Medications

Intent: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident.

In addition, an Antipsychotic Medication Review has been included. Including this information will assist facilities to evaluate the use and management of these medications.

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Section N: INJECTIONS

N0300

Record the number of days (during the 7-day look-back period) that the resident received **any** type of medication, antigen, vaccine, etc.

Insulin injections are counted in this item as well as in Item N0350.

Note: N0300 is a RUG III payment item and N0350 is a PDPM payment item for insulin injections.

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Section Z
Assessment Administration

Intent: The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.

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Section Z
Assessment Administration

The majority of this section is completed by your software.

Z0100 Medicare Part A HIPPS code (PDPM)
Z0200 **State Medicaid Billing** **(RUG III)**
Z0250 Alternate State Medicaid Billing
Z0300 Insurance Billing

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To check your final validation report:
https://sms.muskie.usm.maine.edu/

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Section Z

Z0400 Attestation Statement

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting			
I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.			
Signature	**Title**	**Sections**	**Date Section Completed**
A.			
B.			

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion	
A. Signature:	**B. Date RN Assessment Coordinator signed assessment as complete:** ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

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Section Z - Assessment Administration

Z0400 Signature of Persons Completing the Assessment or Entry/Death Reporting.

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. ***I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information.*** I also certify that I am authorized to submit this information by this facility on its behalf.

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Section Z

Z0400 Attestation Statement

Coding Instructions

- All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed.

- If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.

- Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information.

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FYI…

Chapter 110, Regulations Governing the Licensing and Function of Skilled Nursing Facilities and Nursing Facilities

http://www.maine.gov/sos/cec/rules/10/ch110.htm

Chapter 2.B.1.b Comprehensive Assessment (page 2)

b. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

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Z0500 Assessment Complete

Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete

- ✓ Verify that all items on this assessment or tracking record are complete.
- ✓ Verify that Item Z0400 contains attestation for all MDS sections.

Use the actual date that the MDS was completed, reviewed, and signed as complete by the Registered Nurse (RN) assessment coordinator. *This date must be equal to the latest date at Z0400 or later than the date(s) at Z0400*, which documents when portions of the assessment information were completed by assessment team members.

If the MDS cannot be signed by the RN assessment coordinator on the date it is completed, the RN assessment coordinator should use the actual date that it is signed.

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Section X: Correction Request

Intent: The purpose of Section X is to identify an MDS record to be modified or inactivated. Section X is only completed if Item A0050, Type of Record, is coded a 2 (***Modify*** existing record) or a 3 (***Inactivate*** existing record).

In Section X, the facility must reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

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Section X: Correction Request

A **modification** request is used to correct a QIES ASAP record containing incorrect MDS item values due to:

- transcription errors,
- data entry errors,
- software product errors,
- item coding errors, and/or
- other error requiring modification

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Section X: Correction Request

An inactivation request is used to move an existing record in the QIES ASAP database from the active file to an archive (history file) *so that it will not be used for reporting purposes*.

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Section X: Correction Request: Manual Deletion

A Manual Deletion Request is required **only in the following three cases:**

1. Item A0410 Submission Requirement is incorrect.
2. Inappropriate submission of a test record as a production record.
3. Record was submitted for the wrong facility.
4. Information submitted to CMS in error, such as submitting a 5-day for a resident with Medicare managed care as a payer.

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Section X

Section X: Correction Request

X0150 Type of Provider
X0200 Name of Resident
X0300 Gender
X0400 Date of Birth
X0500 Social Security Number
X0570 Optional State Assessment (No)
X0600 Type of Assessment (matches choices at A0310A, B, F, and H)
X0700 Date on existing record (complete one choice only)

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MDS 3.0 – The Mini-series
Section X

Section X: Correction Request

X0800: Correction number
X0900: Reasons for Modification, (If A0050 = 2)
X1050: Reasons for Inactivation, (If A0050 =3)
X1100: Name, Title, Signature, Attestation Date

Do *not* change the Assessment Reference Date (ARD) as it will change the look back periods for the entire assessment

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MDS 3.0 – The Mini-series Documentation Guidelines

MDS 3.0 Documentation Requirements
August 2020

MDS 3.0 Item	Item Description	RUG III Categories Description	Documentation Requirement
B0100	Comatose/ Persistent Vegetative State (CPS)	*Clinically Complex Impaired Cognition*	Physician documented diagnosis of coma or persistent vegetative state that is applicable during the 7-day look-back period. Does not include residents with advanced stages of progressive neurological disorders. The service plan or care plan must also describe the specific care needs of the resident due to his condition.
B0700	Resident makes self-understood (CPS)	*Impaired Cognition*	Documentation of resident's degree of impairment, ability to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language whether in speech, writing, sign language, or a combination, over **all shifts**. This may include reduced voice volume, difficulty producing sounds or difficulty finding the right words, making sentences, writing and/or gesturing. Observations and interviews with family and/or speech pathologist that were used to justify the coding on the MDS must be documented in the medical record.
C0200 – C0500	Resident interview for cognition (BIMS)	*Impaired Cognition*	Validation of completion of items C0200-C0500 at **Z0400** on or before the ARD Date, **OR** Documentation the resident interview of BIMS items was completed *preferably the day before or day of the ARD.*
C0700	Short term memory (CPS)	*Impaired Cognition*	Documentation to determine the resident's short-term memory status by requesting that staff from **each shift**, validate resident's response to an event 5 minutes after it occurred. See RAI Manual, Section C for instructions.
C1000	Cognitive skills for daily decision making	*Impaired Cognition*	*Documentation by direct-care staff across **all shifts** within the 7-day look-back period demonstrating the degree of compromised decision-making about tasks of everyday living, including choosing clothing, knowing when to go to meals, using environmental cues to organize and plan, seeking*

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Questions?

Forum call for Nursing Facilities
1st Thursday of the month in February, May, August and November, 1:00-2:00

Training sessions for Payment Items and Documentation will be scheduled for March, June, September, and December of each year

Call the MDS Help Desk to register!
- (207) 624-4095 or (toll free) 1-844-288-1612, OR
- MDS3.0.dhhs@maine.gov (email)

To download MDS resources from State of Maine website:

https://www.maine.gov/dhhs/oms/providers/case-mix-private-duty-nursing-and-home-health

Maine Department of Health and Human Services

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MDS 3.0 Training
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Reminder!

- This completes *Payment Items and Documentation* of the MDS 3.0 training.
- Ask questions!
- Ask more question!!
- Use your resources (other MDS coordinators, case mix staff, MDS Help Desk, Forum Calls etc.)
- Attend training as often as you need.

Please complete your evaluations to help us to continually improve training to best meet your needs.

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MDS 3.0 – The Mini-series
Contact Information:

- **MDS Help Desk**: 624-4095 or toll-free: 1-844-288-1612
  MDS3.0.DHHS@maine.gov
- **Lois Bourque, RN**: 592-5909
  Lois.Bourque@maine.gov
- **Deb Poland, RN**: 215-9675
  Debra.Poland@maine.gov
- **Christina Stadig RN:** 446-3748
  Christina.Stadig@maine.gov
- **Emma Boucher RN, RAC-CT**: 446-2701
  Emma.Boucher@maine.gov
- **Sue Pinette, RN, RAC-CT**: 287-3933 or 215-4504 (cell)
  Suzanne.Pinette@maine.gov

Training Portal: www.maine.gov/dhhs/dlrs/mds/training/

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Questions?

Case Mix Team
Sue Pinette RN, RAC-CT
State RAI Coordinator and Case Mix Manager
207-287-3933

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